MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Ronald Reagan Building
International Trade Center
Horizon Ballroom
1300 13th Street, N.W.
Washington, D.C.

Thursday, April 12, 2001
10:27 a.m.

COMMISSIONERS PRESENT:

GAIL R. WILENSKY, Ph.D., Chair
JOSEPH P. NEWHOUSE, Ph.D., Vice Chair
BEA BRAUN, M.D.
AUTRY O.V. DeBUSK
GLENN M. HACKBARTH
FLOYD D. LOOP, M.D.
ALAN R. NELSON, M.D.
JANET G. NEWPORT
CAROL RAPHAEL
ROBERT D. REISCHAUER, Ph.D.
ALICE ROSENBLATT
JOHN W. ROWE, M.D.
DAVID A. SMITH
RAY A. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.

AGENDA PAGE

tomorrow morning to see whether we've alleviated that concern.

Let's vote on recommendation one and we'll postpone recommendation two until we see the rewording tomorrow morning.

All those in favor?

All those voting no?

All those not voting?

Agenda item: Nursing/allied health programs

MR. LISK: Good afternoon. In this late hour, we're going to go back again to our mandated report on Medicare payments for nursing and allied health education which is due the end of May. What I want to first do is just briefly review again the congressional mandate. Congress asked the Commission to really focus on two questions.

The questions in the report were, is there a basis for treating different classes of non-physician health care professionals differently in Medicare's payment policies for GME? And what is Medicare's role in supporting clinical

training? Congress was interested in information on the extent of Medicare's support for financing clinical training for non-physician health professionals.

There are differences in the treatment of clinical training costs for hospital-based programs versus programs sponsored by academic institutions which both may have substantial clinical training in hospital and inpatient, outpatient settings. The program only supports programs that are hospital based and hospital operated.

Also in terms of the question of the different types of health professions is that the types of health professions supported through the pass-through is another issue that I think the Congress is wondering, in terms of psychologists, for instance, and physician assistant programs are generally not supported through the program.

Briefly in terms of reviewing Medicare payment policies for nursing and allied health education. Clinical training costs have been considered allowable costs for facilities since the beginning of the Medicare program. When PPS for hospitals was implemented, clinical training

and classroom costs for hospital based training programs were carved out and paid as a pass-through. But clinical training costs for non-provider operated programs were included in the base PPS payment rates, which is consistent with basically the Commission's views as they've expressed about graduate medical education payments for residents.

With regard to billing on Part B services, only licensed personnel may be reimbursed for Part B professional services provided in the course of training. Services provided by trainees in terms of Part B services are not reimbursable.

There are some basic requirements that HCFA has that a provider must meet in order to meet the hospital provider operated program requirements. It must directly incur the training cost, directly control the program curriculum, control the administration of the program, which includes things like collecting tuition, employ the teaching staff, and provide and control both classroom and clinical training. The program must also be recognized by state licensing organizations or a national approving body. So

those are the basic requirements for a program to meet and be eligible -- a hospital in order to be able to be reimbursed for the direct costs.

Medicare's payments for nursing and allied health, this slide provides some basic information on that. Payments total roughly about $250 million. Two-thirds of these payments are for nursing education programs, which roughly go to a little fewer than 300 hospitals. One-third of the payments are for allied health profession training programs which go to about 550 hospitals.

Now interestingly, roughly two-thirds of these hospitals also receive payments for residents through the current direct and indirect payment adjustments. About half of the major teaching hospitals receiving nursing and allied health payments, and about two-fifths of the other teaching hospitals, although other teaching hospitals receive the largest share of these dollars.

Now this next slide reviews the basic Commission views about education and training costs which we discuss in the report. The trainees bear the cost of general training

by accepting lower wages and paying tuition, and that Medicare's education payment should be treated as patient care cost, and that Medicare should recognize the higher cost of teaching settings if the added costs are commensurate with the added value of the patient care services.

We are uncertain though whether providers who train nurses and other allied health professionals have higher costs. We did take a look at that.

The next slide outlines some of the questions to consider that are discussed in the report. I'm going to go to the first one, then the next slide, and we're going to skip back to this slide. Are hospitals that provide non-physician health profession training more expensive? As you recall, you had suggested that we take a look at what the relationship was by adding in these costs and seeing whether these hospitals have higher costs.

So we can ask the question, are hospitals that provide training more expensive? What we found is per case cost for hospitals receiving pass-through payments are 1.8

percent higher. This estimate though does not reflect differences in the level of involvement in training and cost per case. The estimate may be too low though because it only identifies hospitals receiving pass-through payments. So there's many hospitals that are involved in clinical training that were not counting, identifying here, so that may make our estimates actually too low if those hospitals in fact have higher costs.

The other aspect is the estimate could be too high because these hospitals, in terms of what they are allowed to claim includes classroom-related cost that the other hospitals who may participate in clinical training do not incur. So if the net tuition that's charged doesn't offset those costs that may be an explanation for the higher cost.

But the basic bottom line is we really don't know whether these providers have higher cost. We would need to collect more data on that.

So if we go back to the other questions to consider, we also have the question of, does training contribute to enhanced patient care, which is one of the

fundamental components also of the Commission's previous recommendation. We can make some assumption, as we made for hospital residents that the higher cost we observed, if they exist, may be related to enhanced patient care. But again, we really don't know this for certain and more analysis would need to be made to identify the hospitals and the intensity of training that takes place or something of that sort.

The third question that we discuss is, are there issues that make non-physician training different from residency training? There are a couple of issues that make this nursing and residency training different. First, training for these programs is pursued before the degree is granted, whereas residency training is pursued post-M.D. degree, which you may then consider these things a little bit different for these groups. Residents also receive a stipend throughout their training, whereas most of these trainees in these other allied health professions and nursing do pay some form of tuition.

The paper discusses some of the issues about this

tuition where there are certain circumstances where the student doesn't necessarily bear the full cost of the tuition because of subsidies that schools have and the fact that there isn't necessarily a charging back from the hospitals and other clinical training sites back to the schools.

Now again, there may be no net additional cost. That may be why the hospitals are doing that. But again, we're not clear whether those institutions actually have higher costs.

The fourth issue on this slide --

DR. ROWE: Can I ask a question about that, Craig? Did you consider, do you think it has an impact that the intensity of the training is different? I don't know in these non-physician training programs how frequently people are on all night in addition to all day, and the average resident is in the hospital over 80 hours a week I think.

MR. LISK: That may be contributing --

DR. ROWE: So if you look at the number of residents versus the number of nurses or number of

occupational therapists, that's one way to compare it. But if you look at the number of hours of training that is involved, that might yield some different kind of analysis.

MR. LISK: I totally agree in terms of when you're talking about -- and we'll get to recommendation on collecting data -- is that you would need information, I believe, on the amount of training and the amount of activity that is taking place in a facility. That makes it a very difficult data-gathering exercise though I believe.

The fourth issue in terms of the impending shortage for nursing and allied health professionals, this may or may not make a difference. In general though, the Commission has previously stated that it is not Medicare's role to get into workforce policy, and we do have a proposed recommendation for you to consider reiterating your recommendation you made back in August.

On question five, can hospitals' involvement in training be quantified? As we discuss, we don't really have the data to do that at this point. We again have a recommendation for you to consider for collecting such data,

for the Secretary to collect such data and examine that issue.

Then in terms of the issue of how payments can be adjusted, ultimately the Commission may want to be consistent with its previous recommendations, and we'll also get to that as another potential recommendation for you to make.

Then the final question in terms of what Congress asked, should the various health professions be treated differently in these programs? As we previously stated, hospitals almost never receive pass-through payments for certain health professions. In one issue, HCFA has revised its regulations on that. They have not gone into final effect because of the delays that were made, because this is one of the regulations that was delayed some with the Bush Administration going in, but I believe it will go into effect without any change.

So HCFA eliminated this list of programs, so that's no longer really an issue in terms of hospitals meeting -- if a program meets the criteria that HCFA has,

the hospital will be able to receive reimbursement for those programs if they meet those criteria.

The general other issue here though is the programs not operated by providers, hospitals will not receive pass-through payments for them. When we get down to a final issue for you to consider in terms of short run recommendations we'll have you consider that as well.

So I wanted to provide also some brief review of the Bureau of Health Professions programs that I had mentioned last time but wanted to provide you with some information in terms of the amount of funding for these. The current authorization for Title VII, which does deal with training primarily for physicians, does have subcomponents that deal with allied health professions and physician assistants training. Total funding appropriated in fiscal year 2001 for those programs is about $8 million each. These programs are meant for cost associated with expanding or establishing programs to increase the number of individuals trained in various allied health professions and in physician assistant programs.

Title VIII programs provide funds to support nursing education. Most of these funds go to support nursing education to train R.N. to master's and post-master's certificate programs, to train nurse practitioners, and clinical nurse specialists, and others of that sort, and nurse educators. So that's the vast majority of the nursing money.

So basically nurse education program offers grants to strengthen programs that provide nurse education. The diversity program provides grants to help students from disadvantaged backgrounds. HRSA is authorized to provide scholarships for this program but they lack the funds to do so, they have not.

The loan repayment program provides 85 percent of loan repayment for entry level RNs and advanced practice nurses who agree to work at least two years in health service facilities having critical shortage of nurses, and the Nurse Health Service Corps provides nurse practitioners and certified nurse midwives, education support in exchange for service recognition.

Now in terms of seeing these dollars, as I said, these are much smaller compared to what Medicare currently has in payments for direct -- as its pass-through payments. But the other thing in terms of recognizing scale is, at least in the most recent number I was able to find for the number of nurse graduates, R.N. graduates was about 90,000 back in '95. I think that has shrunk down maybe closer to the 80,000 range currently. So if you think about the number of nurse trainees and the dollars there. Allied health professions though are even larger than the nursing field as well.

So with that I'd like to go to your discussion in terms of the recommendations and your approval. So there are three draft recommendations and then a proposal for whether you want to consider other recommendations.

DR. WILENSKY: Before we get to the recommendations, are there any comments that people would like to make about the information we have?

DR. NEWHOUSE: First a question, Craig. Of this 1.8 percent difference, do you know how much of that is

accounted for by the GME payment of $300 million?

MR. LISK: Basically we threw in the $300 million, so that we get the 1.8 percent effect when you throw in the GME payment.

DR. NEWHOUSE: I know you did that. But suppose you didn't --

MR. LISK: If we don't throw the direct GME payment in we get no effect.

DR. NEWHOUSE: I'm only talking about nurse and allied health part of the GME.

MR. LISK: Correct, that's what I'm talking about.

DR. NEWHOUSE: You got no effect.

MR. LISK: So when you don't throw those monies in, you don't get an effect. When you throw those monies you, you get a 1.8 percent effect.

DR. NEWHOUSE: So I think there's a difference that I'd like to bring out between the how we handled the resident issue and this one, which is -- there are a couple differences I want to bring out. One is, the original resident adjustment was estimated off the old cost

reimbursement system. That is to say, in the world of ancient history, teaching hospitals were more expensive than non-teaching hospitals when all were under cost reimbursement.

Now if I come to this issue and I say, the students are bearing the cost of their training, but now I'm going to give the hospitals that train them $300 million, I wouldn't expect them to stuff it in their pillow. I'd expect them to spend it on something. So I would expect that that would show up in higher costs. However, at one level all I'm doing is advantaging them relative to the hospitals that didn't have these training programs, and I'm not sure I should want to do that.

The difference being that if I'd gone back to the situation before I gave them the $300 million, then the costs presumably would have been the same from what you just told me. Whereas that wasn't the case with teaching hospitals defined as we usually define them with residents to bed. So I'm not sure there's --

The second issue is, as you've said, these are

people that are being trained that aren't licensed. It's therefore not clear to me that I'm getting any kind of different product in the sense that I think I'm getting it from teaching hospitals. That is, the fact that residents are around all hours of the day and night and are actually doing patient care to me suggests that there is a different product in a teaching hospital. The fact that here are people, pre-licensed, being trained, doesn't convince me that there's a difference in the product, or if there is, it's something I should want to pay for.

My recommendation issue is that while I -- that draft recommendation language isn't up there but I would have actually included, if the Congress -- when we talk about supporting number, specialty mix, and geographic distribution through targeted programs I would have inserted, supported from general revenues rather than through Medicare payment policy. I think that's implied but I think we ought to make it explicit.

MR. HACKBARTH: Can I just ask a question of Joe? It sounds to me like that reasoning leads you to the

conclusion that we ought to take out the existing dollars and just save the money, or are you saying we ought to fold them back into base rates without any adjustment?

DR. NEWHOUSE: In terms of these options at the end of the line here that were said to be mutually exclusive in our packet, I would have said we could either return it to the base rates or we could use it, or an equivalent amount for general revenues to BHP. The issue goes back, it's such a minor amount we'll never know, but at this point these are kind of costs in the system. So putting it in the base amount seems to me to be a reasonable thing to do even if they wouldn't have been in the base amount if we'd never had this adjustment in the first place, arguably.

DR. WILENSKY: Also consistent with what our discussion was in talking about graduate medical education where we wanted to make clear we weren't making a recommendation as a cost-saving strategy, and therefore basically did not make use of empirical estimates to justify where to put the amount, but rather regard it as money that ought to stay within the system but be redistributed. It

seems to me we're being consistent either with putting it in the base or giving it to the Bureau of Health Manpower, but not using it as savings.

DR. WAKEFIELD: Just a couple of comments. First of all, the first draft recommendation on Medicare's role is, while I've articulated on other occasions some of the difficulties that I have with some of this language, nevertheless, I believe that that first draft recommendation is, as it reads in text -- not with any other changes, but as it reads in text is consistent with language that we've used previously related to GME, regardless of what health care provider group it's supplied to.

MR. LISK: Correct.

DR. WAKEFIELD: So it seems to me that language is consistent as it reads up there.

MR. LISK: Yes.

DR. WAKEFIELD: I'll just say for the record that I haven't been dissuaded from the notion that there is a need for data collection. I'm sure somebody will talk to me over dinner or another time and explain to me further why

there isn't a need for data collection. But the point I'm making is, I support the second draft recommendation that data should be collected to determine whether or not providers participating in training have higher patient costs in part because, unless I'm misunderstanding your comment on the previous slide that says, some of our estimates may be too low because we're only identifying hospitals that receive pass-through payments.

MR. LISK: That's correct.

DR. WAKEFIELD: And we've got other educational institutions that are placing their trainees in hospitals and those training costs are landing somewhere.

MR. LISK: We're presuming that the trainee is bearing those costs, but those facilities may still have higher patient care cost and there may be extra value that we are getting from that. So we don't know the answer to that question though.

DR. WAKEFIELD: Which is why I would support the second recommendation as it currently --

DR. NEWHOUSE: What data would allow us to answer

that question, the extra value question?

MR. LISK: The extra value really is a judgment call in many ways.

DR. NEWHOUSE: I agree with that.

MR. LISK: How we wrote it in the text was making a consistent assumption with residency training and other types of training may add value, if we see those higher costs and take the assumption that the residents -- and the trainees are bearing those higher costs. If we see higher cost related to this, then that may be added value. So that's the assumption that we made in terms of how we wrote the draft.

DR. WILENSKY: But that strikes me again, with reference to what Joe said, that the presumption of increased value that was associated with having residents within a hospital was based on the fact that having people available to provide services in the middle of the night, or having the availability of state-of-the-art equipment associated with the training of graduate physicians was why we thought there was some kind of enhanced value. One of

the things when we had our discussion about paying for training, that it's not just whether there's higher cost, but being able to rationalize why we think there's enhanced value.

I think we've explicitly at least had the discussion getting ready for our August 1999 report, we don't want to be in the position of saying that we think that there should be financing of higher cost because they're higher cost. It has to be that there are enhanced benefits that are associated with it. I think that was the point that Joe was making, is that when you're talking about undergraduate trainees --

DR. WAKEFIELD: Right, but if I could just jump back in and finish this thought and then I'll be finished. I remember though, at least the way I remember some of the earlier discussions that we had when I first joined the Commission about the notion of enhanced patient care applied to GME, it was a notion in process. It was being developed over the first couple of meetings that I was involved with.

When we were first talking about it, I think we

were talking about issues like being able to quantify improved quality of care, or something like that. The term quality was used pretty frequently. And I remember the asking the question, then supposing that, then probably there must be some research studies that exist someplace that show that quality is different in tertiary care facilities than it is in community hospitals, for example, et cetera, and that's generalizable enough that it justifies enhanced patient care. I was coming in new to this and so querying a fair amount along those lines.

Then I think the point we got to, no, that's -- the point I got to. Let me speak for myself. I couldn't get a sense that that was easy to quantify; that is, higher quality, so we would talk about it in terms of a different product.

DR. WILENSKY: There is some data that shows if you look at best practices that academic health centers have higher rates of best practices. Now what was interesting is that it was like 34 versus 48. I mean, more distressing as I recall is that the best practice places were still less

than, sort of a 50/50 shot of getting it right. But nonetheless, higher than the community hospitals.

It's very difficult to produce good quantified information supporting the enhanced value, but there is information suggesting higher quality.

DR. WAKEFIELD: Then I take your point, Gail, and I'd say that obviously that information exists and it informed people's thinking. And it was significant enough to base a payment recommendation, a revised payment methodology on the data that we were looking at then apparently. That that was substantial enough to suggest that that could happen.

The point I'm making is, that was sort of an evolutionary process about how do we apply these new concepts to GME? I'd say this too is an evolutionary process about how we apply these concepts to something other than medical residency training. I think we committed in our report to say, when you can you demonstrate -- so a reason to collect I suppose -- when you can demonstrate that there's enhanced patient care and higher cost, then payment

methodology ought to follow that track.

I'd say, there are things that happen differently when you've got clinical nursing faculty in an environment. We don't talk about night shifts with nursing students, et cetera, but I don't even recall that much of it, those things being the reason why we're reimbursing teaching facilities. But there are numbers of nursing education programs that require their students, for example, in hospitals to engage in quality improvement projects in those facilities.

So all I'm saying is I don't think that there's enough information to dismiss this out of hand, and that there's probably a reason to collect data to see whether or not there's a difference.

DR. WILENSKY: But there should be more than data just on cost.

DR. WAKEFIELD: Yes, I agree. Absolutely I agree with you.

DR. NEWHOUSE: This recommendation is framed as just numbers of people being trained.

DR. LOOP: I have a question about folding the education payments into the base rates. Right now I believe that the financial support is only to the hospital that have the training programs. So I guess you're talking about $250 million here. So what would happen if you do that? I think we're in the middle of a nursing shortage. Are there some unintended consequences? We've got a shrinking number of nurse applicants and a shrinking number of education programs. If you fold this into the base rates does that cause programs to have less incentive to train?

DR. WILENSKY: It's why, I think, one of the other recommendations has been to have this money available to the Bureau of Health Manpower specifically for encouraging individuals going into nursing. One of the questions -- part of it you can fold it into the base. Part of it is that you can try to target it more directly to what you think might actually support alleviating a nursing shortage, and the question of whether it has to do with training sites is a real question.

DR. LOOP: I think we should be fairly clear on

this because one of the premises of this chapter is not to intentionally distort the supply of health professionals. We could be indirectly doing that.

DR. WAKEFIELD: To the extent that you leave it to the discretion of Congress -- and I'm sure there's nothing wrong with that -- but there were plenty of groups that were fairly concerned when there was a discussion of moving residency training dollars over to the discretionary account and out of GME. I would just suggest that the same concerns will exist. That while we can recommend here that $235 or $250 million ought to be appropriated; maybe, maybe not, as was the case with residency training; maybe, maybe not.

DR. NEWHOUSE: Yes, but the difference is that there was compelling evidence, for me at least, that even before we instituted the GME payments that patient care costs were higher at teaching hospitals. And therefore we could legitimately, at least I could legitimately classify those higher costs as patient care costs.

Here it doesn't -- first of all, 1.8 is tiny compared to the difference between teaching hospitals and

non-teaching hospitals where we're talking about 50 percent or so kinds of differences in cost. But secondly, it's not clear that we would have any difference in cost if we hadn't put in this program.

DR. WAKEFIELD: The point I was responding to with Floyd was what might this do to supporting workforce, which I know we say we have nothing to do with here. My comment is, basically if you, for example, eliminated this $250 million out of GME for nursing and allied health and moved it, moved the notion over, recommended that it be appropriated out of the Bureau of Health Professions, maybe, maybe not. It was that piece of what he was talking about that I was commenting on.

DR. NEWHOUSE: But we said, keep it in the Medicare program in the residency because it was really a patient care cost. It's not clear that this is a patient care cost.

DR. WAKEFIELD: I'm not disagreeing with what we said. I was only responding to, what could this do?

MR. HACKBARTH: As I understand it, the trend has

been away from the hospital-operated programs towards programs run by academic institutions. It seems to me that that's relevant in evaluating the extent to which this is useful in dealing with the nurse shortage.

If in fact, for other reasons, everything has been moving toward the academic side, away from the hospital-operated programs, that suggests that there are substantial forces going the other direction that aren't really dictated by the availability of these dollars. The dollars are there, and still everything is going towards the academic programs, away from hospital-operated programs. Given that, this seems like an awful weak reed to use to deal with the shortage.

MR. DeBUSK: Glenn, I agree with you. You think about where the dollars are going, are they going in the right direction to help with the nursing shortage? I think are we all aware of how bad this shortage is right now? I've got an example I want to tell you about, just to reiterate the continuation of the shortage.

At Lincoln Memorial University we've got some

graduates who live in that rural area and the hospital in Roanoke has got a program now, if an LPN will come up there and work three days, put in the hours in three days, they'll pay them $42,000 for those three days to travel 200 miles and spend those three days. Now you want to know about a shortage. If you don't demonstrate what a real shortage is, I don't even know what we're doing here. We're certainly not addressing the shortage.

MR. HACKBARTH: I'm prepared to stipulate that the shortage is a real issue, a critical issue. For that reason, I think we ought to do real and substantial things about it. I think continuing this program the way it's been historically is just inertia. It's not dealing with the issues of today. So I'd rather see us redirect the money through a mechanism that's likely to be helpful, as opposed to just continue this because it's got nursing on the label.

MR. LISK: Just to provide you with some brief information. You received a packet from the nurse anesthetist groups and they had some information on the changeover from hospital-based to academic-based programs,

and in terms of the proportion of the programs therefore receiving some -- hospitals receiving money for some of those programs. It changed from in '92, 68 percent of those programs were receiving some support through Medicare, or hospitals receiving support for those programs. That declined to 30 percent in fiscal year 2000 in terms of how those programs were functioning. So that's one example.

There's a small number of those programs relative to overall nursing, 83 total, but that gives you some idea in terms of that shift.

DR. WAKEFIELD: Could I just ask Craig a quick question? Craig, to Glenn's point, do you have the data on how many of the hospitals that are provider-operated training programs operating associate degree versus diploma?

MR. LISK: Most of them actually I think are associate degree programs today. Of those 300 or 270 or so hospitals, less than 100 now today I think are diploma programs. So most of the others are associate degree, and there's a few B.A., BSN programs in there, too, and a few master's level as well. But it's not really an issue any

more of the diploma because those are really disappearing. So some of them are hospital-based associate degree programs that have developed from those.

DR. WILENSKY: We have four recommendations. Why don't we try and look at the first two, and then we can look at three or four or something different? The first one reiterates the position that Mary has mentioned that was part of our August 1999 report that to the extent that Congress wants to affect policies influencing the number and distribution of health care professionals, it should do so through specific targeted programs and not through Medicare.

DR. ROSS: We may Anglicize this a little bit. The original recommendation began just, federal policies, but we like to have actors. So if you read it as, if the Congress wishes to influences the number, and then just carry on.

DR. NEWHOUSE: I would insert, supported from general revenue, just for clarification, after specific targeted programs.

DR. WILENSKY: Any further discussion on this

before we do a vote?

All those voting in favor?

All those voting against?

All those not voting?

Let's look at the second one with data collection.

DR. NEWHOUSE: My issue here, Mary, is this seems to me to presuppose that we're going to have a payment system. And if we're not going to have a payment system, then we may just put a lot of burden to report data that will never be used.

DR. WILENSKY: I thought it was more the question of what -- we're not saying anything with regard to how we're going to try to assess enhanced patient value.

DR. WAKEFIELD: Enhanced patient care. That I don't have a problem with. I agree, because that would be consistent with where we've been historically.

DR. WILENSKY: Right. Is that if we're going to have data collection, it has to include some measure of differential quality.

DR. NEWHOUSE: I guess the issue is -- I mean, at

one level I agree with that. At another level is sort of, is the game worth the candle? We've got something that's a $300 million program. Do we really think we're going to demonstrate any differences -- be able to see any differences, even if they were there?

I think the original spirit of this was, if we were going to have some mechanism to pay for these people, we were going to have to collect data on numbers. We could answer then questions about, if you had more of them, did it cost more and so forth and so on. I thought that was where this was coming from.

DR. WILENSKY: Again, in the spirit of where we had started this discussion, I am comfortable that we're not being consistent -- although we can say that at a conceptual level, the theoretical expectation may be less, but that we're not being consistent if we don't attempt to see whether or not there is enhanced patient value as measured by quality differentials or other measures associated with institutions that do clinical training, as well as any difference in cost.

DR. NEWHOUSE: We relied on the literature basically in the case of teaching hospitals.

DR. WAKEFIELD: Have we even looked at the literature for this?

DR. NEWHOUSE: I haven't.

DR. WAKEFIELD: I haven't either.

DR. NEWHOUSE: But I just can't imagine that for this small a difference you could in fact see anything.

DR. WAKEFIELD: You may not, but to me it's an issue of consistency with our previous actions. And also what drives it a little bit for me is we really don't know.

DR. NEWHOUSE: I agree with you on both consistency and we don't know. The issue is it's going to cost us something to find out or to make the attempt to find out and I'm making a judgment about --

DR. WILENSKY: But nothing like $300 million. It's going to be a relatively small cost to do a study to try to demonstrate.

DR. NEWHOUSE: On the value side?

DR. WILENSKY: You do a sample of hospitals that

are involved.

DR. ROSS: Or you do a study that's appropriate to a $300 million expenditure.

DR. WILENSKY: Exactly.

DR. NEWHOUSE: All right.

MS. RAPHAEL: Is the study just relevant to the hospitals that are --

DR. WILENSKY: In order to try to establish whether or not there is enhanced value at such hospitals, you'd want to do a sample of hospitals that had clinical programs and then a sample of hospitals that you thought would be otherwise comparable, or of some variation in hospitals that didn't have clinical training programs, and to see whether or not there was some kind of differential quality or other measures of enhanced patient value. So you'd look at some range of hospitals, but certainly including hospitals like the ones that had clinical training programs who didn't have clinical training programs.

DR. NEWHOUSE: We're talking about all clinical training programs, not just nurses, right?

DR. BRAUN: If we're going to be consistent, aren't we talking about post-graduate education and not undergraduate education?

DR. WILENSKY: That is, of course, a problem that Joe mentioned, is that we're talking about undergraduate medical education. But again, to the extent that --

DR. BRAUN: So that's not consistent with --

DR. REISCHAUER: But I think it's very hard to think of the theory in which an undergraduate education would lead to enhanced value --

DR. WILENSKY: I agree.

DR. REISCHAUER: -- except with one definition of value. That is that this could be labor substitution on the part of the hospital, and therefore their costs are actually lower.

DR. WILENSKY: But we're talking about patient value.

DR. REISCHAUER: And it's value to them, but it's not value to the patient. Beyond that, Mary, the only thing you can hang your hat on is the teaching faculty --

DR. WAKEFIELD: Which is the point I was just going to make.

DR. REISCHAUER: -- and that they might change the behavior within these types of institutions.

DR. WAKEFIELD: Which is part of the rationale we used when we were talking about the availability of not just residents but the subspecialists with whom they were working, et cetera. That the dynamic, the mix of physician providers in teaching facilities was different than it was in community hospitals.

DR. REISCHAUER: I would wonder, how many of these institutions aren't also training residents and other people, and how you would ever disentangle this. I mean, it's a morass and you have an elephant walking around and you're trying to figure out what effect the mouse has.

DR. WILENSKY: Even if they have residency programs, there will be other programs that have residency programs that don't have clinical training.

Now to be perfectly honest, I think the likelihood of being able to find a difference is very small. But I

think that given in the spirit in which we have said we ought to look at both increased cost and enhanced patient value, that we ought to be able to look at either a difference in patient outcomes for some kind of protocols, or attempt to find some measure, or look at the literature to see whether there's any studies that in fact show an enhanced patient value with some definition in these institutions.

I don't think it's very likely that you're going to see the difference because of the kinds of variations that you're going to see among these, and I think we ought to focus on nursing because that's where the concentration of the money is. But rather than just be dismissive that it's not there, then I think we ought to make this recommendation that we do such a study.

DR. ROSS: And maybe add at the end, and provide enhanced patient --

DR. WILENSKY: Yes, the data collection has to have a phrase at the end, and provide enhanced patient care, measurable enhanced patient care.

DR. ROSS: Or whatever words we used before. I think it was just additional value or something.

DR. WILENSKY: Okay.

All those voting aye?

All those voting no?

All those not voting?

We are adding a phrase at the end that says, and provide enhanced patient care.

DR. ROSS: Glenn, your vote was?

DR. WILENSKY: You can do any of the three.

MR. HACKBARTH: I'll vote no.

DR. WILENSKY: Did you vote?

DR. NEWHOUSE: I voted, not voting.

DR. WILENSKY: All right, the next recommendation.

MR. LISK: This recommendation is -- you may want to add in, and there is commensurate higher cost -- say, patient care costs are higher and there's commensurate added value, or something to that effect, to reflect your higher value if you wanted to put that in there in terms of reflecting the previous statement.

The other issue is though, the eventually in here, is whether you want to -- the eventually should be in here or not. Because one says to fold it in immediately and then develop an adjustment. The other would be meaning that you would do this once you potentially have an adjustment and see what's there, if it's appropriate.

DR. WILENSKY: We're clearly not ready to vote on the second because we don't know the answer to it. We can consider either the first statement or we can look at the short run recommendation.

MR. LISK: Actually if you wanted, then you can actually consider the first statement in the series of short run recommendations here that you'd be considering, because you could make it a short run or -- it's a short run recommendation.

DR. WILENSKY: Really the alternative to that is, the first bullet on the short run recommendations as it's now listed is that eventually fold the pass-through into the base, or eliminate the current pass-through and appropriate additional funds for Title VII and VIII for nurses and

other, is an alternative to putting it in the base.

MR. LISK: Correct.

DR. NEWHOUSE: Is the thrust of this that we're preserving the pass-through because we don't know the answer yet?

DR. LOOP: Why don't you take the last sentence of this and put it on the previous recommendation? If the costs are higher from your study then you --

DR. WILENSKY: Only if you get also enhanced value. You then need two pieces to the study, both that the costs are higher and that they're something you want to pay for.

DR. ROSS: Since that's conditional, how about we put that in the text and bring back the discussion from the last report, which is what's motivating the study? That MedPAC has been supportive of additional payment where there's --

DR. WILENSKY: Of paying for additional costs --

DR. ROSS: Where there's higher cost and --

DR. WILENSKY: -- where there's higher value. I

think that's an appropriate way of doing it.

I don't know until we have some feedback that we're really in a position to say that we should take the money and either fold it into a base or have a direct appropriation. So I think we just have to wait.

MR. HACKBARTH: By asking for this study, are we going to put ourselves in the position where if they don't act on doing something through another more direct means, because there's this study and a potential future Medicare adjustment hanging out there, and so we end up just sort of frozen where we are?

I'd just rather say -- and I know I'm in the minority but I will just go ahead and say it anyhow. Let's not do a study that we don't think is likely to be productive. Let's take it out of Medicare and do something meaningful through the direct appropriation channels. This is a real issue, a critical issue. Let's get on with it. Let's not study potential future Medicare adjustments.

MS. RAPHAEL: I think the peril in that approach is that if you look at what the appropriations are now,

they're much less than this $300 million, and how would we know that this $300 million in fact would ever get transferred?

MR. HACKBARTH: Ultimately we will never know. It's in Congress' hands what happens. All we can do is say what we think should happen.

DR. NEWHOUSE: And the presumption is that the $300 million is actually doing something useful instead of just dropping down out of the sky on some hospitals.

DR. WILENSKY: I agree that makes more sense. Again, it was within the spirit of where we were, of dismissing whether or not there is any measurable enhanced patient value, when Mary is rightly calling our hand that we said that that was the approach that we were going to do.

MR. DeBUSK: If we've got $300 million falling from heaven, why don't we do something constructive with it, like train more nurses?

DR. WILENSKY: But the problem isn't training.

DR. WAKEFIELD: But we're not saying, take this money and move it en bloc over into the appropriations side

of the ledger. We can't do that, and we're not saying that. So we leave it to the discretion of our colleagues -- colleagues is an overstatement -- the senators just a mile from here, and whether or not they choose to take this $250 million and move it over.

Some hospitals I think would say right now that, yes, they run training programs, but it's extremely difficult to keep those training programs -- to provide learning environments for those students. They have every incentive to do it because they want to recruit, retain, et cetera. But you've got front line shortages of health care, of nurses -- using nurses as an example -- and then you're trying to superimpose on top of that a training operation, when these nurses are already stretched like this [indicating].

So I'm a little concerned if we say, okay, we're going to take that money back from the hospitals, that that's not going to even jeopardize what they've got available right now, or at least what they're choosing to put into their resources. It's a tough environment just to

provide patient care, let alone putting students into that mix and expecting all things to work smoothly.

DR. WILENSKY: We are, of course, in the first recommendation indicating that to the extent that the Congress wants to try to alleviate the nursing shortage, they ought to do it through direct policies outside of Medicare like the Bureau of Health Manpower or any of the other policies that they can come up with.

So I think basically our first recommendation, it's only a question of whether we suggest taking the specific money and moving it, and I think until we have done the study that we had said it was appropriate. So I think we ought to stay with our first two recommendations and stop. I don't think there is anything more to say at this point.

We're not going to vote. We are going to ignore that and the follow-on recommendations. I think at this point we don't have anything more to say than if Congress wants to try to influence it, it ought to do so outside of Medicare.